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QNCC
QUALITY NETWORK FOR COMMUNITY CAMHS

Jersey Care Commission

2024

Inspection Report

Jersey CAMHS

Jersey Care Commission

Review Date: November 2024

Contents

Background

This is the second annual inspection of the Jersey Child and Adolescent Mental Health Service (CAMHS), operated by the Government of Jersey's Children, Young People, Education and Skills (CYPES) department. The Jersey Care Commission (the Commission) conducted this inspection, evaluating the service against the established standards for CAMHS.

The Commission once again engaged the Royal College of Psychiatrists (RCPSYCH) and their Quality Network for Community CAMHS (QNCC) to support the inspection with an external review team alongside two Regulation Officers from the Commission. This decision was based on their expert knowledge and extensive experience in children's mental health services across the United Kingdom (UK), as well as their proven ability to assess and support improvements in the quality of care provided.

There are five different teams within the CAMHS service which is based within the Government of Jersey department for Children, Young People, Education and Skills (CYPES). As last year, this inspection focused on the 'Specialist CAMHS Service'. The twelve areas of improvement identified at the last inspection were reviewed, and the outcomes of these are in the report.

The report also references other service areas where relevant. The inspection utilised various methods of information gathering, including pre-inspection surveys for young people, parents/carers, and staff. The service conducted a self-review against both the published standards and the QNCC practice standards. An onsite external peer inspection validated the self-review and supporting evidence, with discussions taking place during the inspection. The peer inspection team included specialist practitioners from various UK CAMHS services, the QNCC project lead, and two Regulation Officers from the Commission.

This report triangulates the range of inspection activity and centres on highlighting the service's achievements and identifying areas of improvement. Collaboratively with the service, areas for development were identified throughout the inspection.

Introduction

Peer review day

The inspection review was held on **27** and **28 November 2024**.

CAMHS took part in an inspection covering the following sections of the service standards:

- Statement of purpose
- Service management and leadership
- Staff recruitment and support
- Access, referral and assessment
- Care and intervention
- Information, consent and confidentiality
- Rights and safeguarding
- Transfer of care
- Multi-agency working
- Staffing and training
- Environment and facilities

A visiting team and two Regulation Officers from the Commission spent two days at the service speaking to the host team about the service. This followed a self-review where local staff rated themselves against the standards.

The main purpose of the review was to highlight the service's achievements, as well as to provoke more detailed discussion on areas the service wished to target for improvements and establish some action points for the future.

Self-Review

As well as the self-review workbook, data was collected from various sources, including surveys provided to children and young people, parents/carers, and a staff survey. Policies, risk assessments and other evidence provided as part of the services self-evaluation was also reviewed.

Source	No. of questionnaires returned
Parents/Carers Questionnaire	14
Young People's Questionnaire	11
Staff Questionnaire	21
Referrers Questionnaire	3
Service Manager Questionnaire	1
Case Note Audit	10

Interviews

Information was collected through various interviews containing a combination of open and closed questions.

Young people – 3

Parents/Carers – 6

Partner Agencies – 3

Multi-disciplinary Staff – 4

Review team

The review team consisted of:

Profession	Organisation
Deputy Programme Manager	QNCC
Carer Representative	QNCC
Senior Nurse Consultant	UK Trust (CAMHS)
Associate Medical Director, Consultant Child & Adult Psychiatrist	UK Trust (CAMHS)
Team Manager	UK Trust (CAMHS)
Regulation Officer	Jersey Care Commission
Regulation Officer	Jersey Care Commission

Limitations

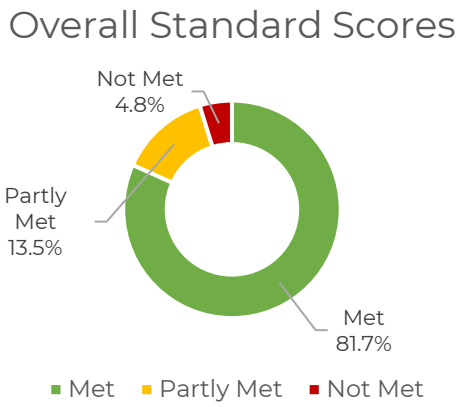
This report summarises the views of the service staff, service users, parents/carers and the peer review team about the service's performance against the QNCC and the Commissions' standards. The findings presented here should be viewed in the context of the range and number of partner agency representatives interviewed and the number of young people and parents/carers interviewed. The views presented in this report are based on feedback provided by service users and their families during interviews. The speech bubbles reflect representative summaries of their experiences. This report is not a definitive statement of performance in any of the

areas covered by the QNCC standards as such judgements could only be made by a much more detailed process than that used by the QNCC network.

About this report

This report summarises the review findings and highlights areas of good practice, as well as areas for development and improvement. The main body of the report details the key issues arising from the self and peer-review discussions, and the numerical summary of scores achieved. Note that QNCC/JCC standards represent best practice, and it would be unusual for any service to meet all of the standards. When criteria are not met or partly met, this will serve as an important indicator for service development planning. Where action points were established during the reviews, these have been recorded in the report to help staff implement the improvements discussed.

Overall Summary



Areas of Achievement

- CAMHS has made significant changes and improvements to their service following feedback provided at last year's inspection. This shows a dedication to quality improvement and a commitment to providing a high-quality service for young people and their families.

- For example, the service is now providing accessible carer's information, including leaflets and a CAMHS Welcome Guide. The Welcome Guide provides very useful information about the service, how to access further support, how to provide feedback including complaints, and what to expect from initial assessment. This was seen as a real improvement since last year.

- It was fantastic to see that the service has started collecting and reviewing data on who is using their service, and how this compares to local population statistics. This work will be supportive in ensuring that they are delivering equitable care.

- Additionally, it was positive to hear the improvements made to collecting and reviewing outcome measures. The team described how they have been discussing this in their monthly meetings, management meetings, and at governance oversight groups to embed this practice. This work is ongoing; however, it was reassuring to hear from frontline staff that they are collecting this data routinely.

- Since their last inspection, the service has made great improvements to how lessons learned from untoward incidents are shared with the team. It was great to see evidence supporting this standard, and to hear frontline staff confirm that this is part of their practice.

- The service has added a useful video to their website explaining their complaints and compliments procedure. This is a valuable resource to share with families upon accessing the service.

- Additionally, there were some good examples of how the service responds to young people's feedback seen by the review team. The reviewers particularly liked the "you are saying, we are doing" poster which explained changes made to the environment following feedback from young people.

- It was fantastic to hear that the service has now implemented an agreed protocol for joint working with local police following feedback from last year's inspection.

- The review team felt that it was also a real area of achievement that young people have access to an easy read service strategy. This ensures that the public are aware of the goals and development plans of the service.

- The service has plenty of green and blue space nearby, and it was fantastic to hear about the initiatives used to support young people to access this. For example, clinicians regularly take young people out for walks, the assistant psychologist will play tennis with clients, and there is also a nature therapist who works within the service. The service also recently facilitated a two-day outdoor event for families and staff.

- Evidence submitted suggests that the induction process for the service is robust. The review team were particularly impressed with the welcome letter, which is sent to new staff. This letter includes valuable information about their first day, required mandatory training, and important contact details.

- It was positive to hear that frontline staff felt that the service supported their health and wellbeing. Some examples of wellbeing initiatives included a social committee, yoga and mindfulness sessions, and "walk and talk" supervisions.

They described managers as “available” and “having their backs” and expressed gratitude for investment in the service which has meant that the team has been able to grow.

- Most parents/carers and young people fed back that they received useful information at their first appointment, that the process was thorough, and that they felt supported well.

- Moreover, young people and their parents/carers gave some very complimentary feedback about the staff team. Many described how clinical staff made them feel safe, how they were friendly and understanding, and how they supported their family well. They also mentioned how the reception team were kind, supportive, and responsive to their needs. Overall, they described feeling that staff respected them and treated them with dignity and respect.

- The service received plenty of positive feedback from their partner agencies. Highlights include the following:

    - Youthful Minds described significant successes in working with CAMHS, including their involvement in the interview process, creating resources for families such as leaflets, and working on collaborative projects.
    - Feedback from Family Nursing and Home Care (FNHC) described how joint working had improved over the past few years – particularly with communication and collaboration.
    - Feedback from SENCO/schooling explained how the referral process, which now goes through the Children’s and Family Hub, has massively improved and is a “solid process”. They also described other successes including the CAMHS Welcome Guide, clinicians making regular contact with children in their school, and that the team responds to crises promptly.

- The review team were impressed with the environment, and noted significant changes made since the last inspection. Some areas of achievement highlighted were as follows:

    - The waiting rooms are young person friendly, with toys and colouring books available, and artwork made by young people on display.
    - Staff have more access to clinic space, because the Children Children's Social Care have relocated from Liberte House, and so they can use the rooms on the ground floor. There are also plans for staff to be able to use the office space previously occupied by Children's Social Care which will be supportive in allowing them to complete their administrative work.
    - Last year it was noted that telephone calls which included personal information about young people could be heard in the reception area, and so it was great to hear that reception staff had been given training on confidentiality since the last inspection.
    - Additionally, the review team were particularly impressed that the team have started playing music in the waiting area so that conversations are less audible. The service explained that they previously played the radio, but following feedback from young people who did not want to hear the news, they are playing music playlists instead.
    - It was fantastic to see a defibrillator available in the clinic following feedback from last year's inspection.

- It was great to hear that there are plans for the service to move to a new building when their lease at Liberte House expires. This new space will be bigger, have more office and clinic space, and will not be shared with other teams. Young people explained that Liberte House is on the route to local schools, and so they can sometimes feel uncomfortable if their peers see them go into the building. Therefore, moving the clinic elsewhere could be beneficial in protecting the privacy of young people who access the service.

Young people experience

[Staff are] super friendly, kind. I immediately liked them. [They are] very friendly and firm but in a good way. They said things like you need to do this to get better.

I've always felt seen and not treated like a child.

The people on reception were really nice.

[Staff are] very kind, caring. Always had a smile.

[I] could not have asked for better care.... They always put a smile on my face.

[CAMHS has] helped. I think having someone there all the time who knows you and is dedicated to you [...] I can take my guard down and really say what's on my mind which is really useful [...] There's nothing I would change.

Parent/carer experience

When we got to CAMHS everything was shared brilliantly. We wanted help and that's what we got. We felt safe and we got the help we needed.

[Clinician] made my child feel at ease... I felt confident that things would be OK.

My [child] always found the environment to be safe.

[Jersey CAMHS] saved us and our child.

The admin staff are outstanding. They are perceptive and so supportive.

We were treated with dignity and respect 100%.

We cannot fault CAMHS. Some staff members were legends and helped hold us together. They were supportive, empathetic, and there for us.

If [other parents/carers] said they were coming to CAMHS I would tell them it's brilliant.

[Staff member] has changed our life.... It genuinely saved us. They are experienced professionals.

Areas for Development

- The service has worked hard to develop some policies specific to CAMHS operational practices, addressing an area identified for improvement in last year's inspection. They have prioritised risk management by implementing a Safeguarding Policy and a Special Observation Policy for Inpatients, for use when working with the adult mental health inpatient facility.

  It was acknowledged that the service does not always have direct control over creating policies, as this is often held at a corporate organisational level. However, it is important that relevant policies are created as a priority so that staff have access to clear information and can work consistently. Additionally, there were policies noted to be out of date including the Whistleblowing Policy, and the Lone Worker Policy.

  Recommendation:

  The Registered Provider is responsible for ensuring that staff have access to relevant, up-to-date, and ratified policies for a CAMHS service, certain critical policy areas will require direct input from the service itself. The review team recommends that, when developing new policies, the provider should consider consulting with other QNCC members to review their policies as a reference point for creating their own.

- The service works regularly with Jersey Youthful Minds, Jersey Youth Parliament and local charities to collaborate on changes to the service. However, the team recognises the need for in-house young people and parent/carer forums to ensure that current service users can feedback and adapt the service. Furthermore, the service acknowledged that it would be useful to have a parent/carer support worker in place to provide support for families accessing the service. This was also raised in parent/carer feedback, and it was mentioned that families would be interested in peer support groups.

Recommendation:

It would be useful to allocate a participation lead or champion in the team to set up a young person forum and a parent/carer forum. These forums could help make decisions about the service, attend stakeholder meetings, and would be particularly helpful in providing feedback on the environment and suggestions for the new clinic space. The service could also explore how to support families further – either by providing regular peer-support group meetings, or by obtaining funding for a paid, parent/carer support worker position.

- It was great to hear that in the last quarter, the service had seen young people for initial assessment within 28 days. The service did not provide the review team with data on how quickly young people with urgent mental health needs can access a mental health assessment. During interviews with young people, it was raised that they received little support while waiting for their first appointment.

  Recommendation:

  The review team encourage the team to continue their work to reduce waiting times, as reflected by their last quarter data. In the meantime, they could consider ways to support young people waiting for their initial assessment, for example by conducting check-in phone calls, or connecting them to local support groups. Additionally, the team should ensure that data on urgent referrals is captured clearly so that the team can monitor this and ensure that young people are seen within 24 hours when they require urgent care.

- Young people and families cannot directly self-refer to the specialist service. However, the team clarified that they could contact the Children and Families Hub, where a CAMHS Nurse is available to screen inquiries and make appropriate referrals to the service or direct them to other suitable services.

Feedback from parents and carers indicated challenges in accessing the service through their GP, highlighting the need to promote the Children and Families Hub as an alternative access point.

Recommendation:

The review team encourage the service to advertise that families can contact the Hub if they have concerns about a child or young persons' mental health. This could be included in leaflets and shared with schools, GPs and other referrers so that young people and their parents/carers are aware that they can self-refer into the service.

- When reviewing surveys completed by staff and referrers, it was not clear if staff are routinely contacting referrers when young people were not brought or did not attend initial appointments. Additionally, the staff team confirmed that they are not consistently sending out correspondence detailing outcomes of assessment within a week. The service described pressures on administrative staff which has meant that this is not always completed as quickly as they would like.

  Recommendation:

  The review team recommend that the service reminds the staff team to do this consistently. This could be monitored in supervision and discussed in team meetings. Additionally, the team should ensure that letters detailing outcomes of the assessment to the referrer, the GP, and other relevant services are sent within a week of the assessment. Protected administration time, both for the clinical and admin team, could be built into the assessment day to ensure that staff are able to do this.

- The evidence seen demonstrated that there is a process in place to allow young people to change their clinician if there are problems. However, young people were not always sure about this. Parents/carers also fed back instances where they were not happy with their clinician or their child's care, and how they were not offered alternative options. Therefore, it would be useful to explore how this mechanism could be communicated more clearly to families.

  Recommendation:

  A poster detailing the process of changing clinician would be a useful resource to display in the waiting area, so that families are aware of their rights. Additionally, the service should check-in with young people and parent/carers on a regular basis to ensure things are going well throughout their care.

- From the evidence provided, it was seen that medication audits have not been completed this year.

  Recommendation:

  It is good to hear that an audit on antipsychotic prescribing is taking place. This should be prioritised to ensure that prescribing practices are compliant with national guidelines and ensure the safety of young people.

- Staff confirmed they receive supervision, however the service needs to improve how this is recorded and monitored, as the frequency of supervision was not clear in the evidence provided.

  Recommendation:

  The service should review how clinical supervision is recorded, so that management can see if there are any barriers to regular clinical supervision. Reasons why supervision is missed should be recorded, monitored and addressed where possible.

- While it is great that staff are compliant with most mandatory training, the review team felt that training was not recorded helpfully as it was hard to clearly see compliance. Additionally, there were gaps in training including training on Capacity and Self Determination (Jersey) Law and recognising and communicating with young people with cognitive impairment or learning disabilities. There were also gaps in physical health assessment training, however it was helpful to hear that the service plans to deliver this in-house in early 2025.

  Recommendation:

  The service should explore how they are recording training and ensure that the team's training requirements are reviewed regularly. Additionally, the team should explore whether they can access training on Capacity and Self Determination (Jersey) Law through an identified local provider.

- All staff seen were wearing lanyards which made them identifiable to the public. However, the service explained that some staff were reluctant to create a display board with their pictures and names.

  Recommendation:

  The review team strongly recommend that the service implements a display picture board of staff, as it can help young people feel more settled before their appointment. With Jersey being a small island, this could also help families identify if they know any clinicians in the team and inform their key worker to avoid conflicts of interest.

- Parent and carer feedback has highlighted their experience of a difficult relationship between CAMHS and the hospital Paediatric ward. Issues such as poor communication and negative interactions between the teams have raised worries about the quality of shared care arrangements for their children. These concerns were echoed in frontline staff interviews, who acknowledged challenges in their interfaces with the ward.

  Recommendation:

  The service should work on improving their relationship with the Paediatric ward. While joint meetings to discuss admissions and support staff are beneficial, additional steps such as providing training for the Ward and scheduling regular catchups could further enhance collaboration and support.

- Some families were not sure whether they were given information on how to access additional support, whether they were asked for consent to be treated, or whether they were told if information would be shared with external agencies.

  Recommendation:

  The service should ensure that this information is explained thoroughly with families during initial assessment. It could be useful for clinicians to go through the CAMHS Welcome Guide in this session, so that families know they can access this information at a later date. The team could also create an assessment checklist to ensure clinicians remember to cover all this information during assessment.

- The service confirmed that clinicians can request a portable alarm from reception to take into consultations with young people and/or family members, if risk highlights a need for this. Parents/carers can access staff in an emergency; however, they were not sure of this process during feedback sessions.

  Recommendation:

  The review team recommend that clinicians take in portable alarms to every session, even if a young person is considered low risk. It can sometimes be hard to predict whether incidents may occur, and so this could protect clinicians and young people in an emergency. Additionally, clinicians should go through emergency protocols with families when they first access the service. This could be included as part of an assessment checklist.

- Partner agencies raised some challenges in their joint working. Challenges raised were as follows:
  - A partner agency raised that there can be long wait times between initial contact and intervention. They also described how clinicians have sometimes given unhelpful or inconsistent advice to young people and can sometimes be hard to reach.
  - They also stated that sometimes referrals will be rejected with alternative interventions suggested, even when the young person has received this intervention and requires further care. They also explained that it can be frustrating that the service will accept cognitive assessments for some children, but for others will suggest a referral to Educational Psychology for this assessment.
  - A partner agency stated that communication could be better. They explained that it would be helpful to set up more meetings, share reports once they have been conducted, and collaborate more to ensure that young people are supported properly.

Recommendation:

The service should consider ways to support their partner agencies further. They could consider setting up referral meetings and discussions so that their decisions can be explained, and alternative options discussed together. Additionally, the service should set up regular professionals' meetings when they are collaborating on a young person's care.

Young people experience

[There was] no support while waiting, other than a leaflet on other services.

After a few weeks a [care] plan became apparent, but I wasn't involved in developing this and don't have a copy.

There are weird stains on the chairs [at the clinic].

Everyone walks that way [past the clinic] from school. If I see someone I know I always wait to enter.

Parents/Carers experience

[Our] GP was a barrier. There needs to be a way for parents to ask specialists about eating disorders.

[The care plan] is not written down in a document... we make our own notes.

I don't recall if [we] were involved in developing a care plan... I don't remember ever having seen a care plan for my [child].

The relationship between Robin Ward and CAMHS is horrible [...] If anything needs to change it's the relationship between [the] hospital and CAMHS as this impacted on family experience.

The relationship with the therapist and the child is key, and CAMHS need to ensure that it is the right therapist in the context of this.

[We] requested a care plan, and [we] were told it was done in the background.

I would have really benefited from being able to speak to people who have gone through this and who understand, such as a peer support group [...] They should ask parents who would be willing to support other parents going through this.

The building is fine [but] it's a bit cold or too hot.

[The clinic] front door is on route where kids walk from school. It would be useful to come in at the back entrance as my child didn't want to be seen.

Areas for Improvement

- The child friendly care plans evidenced were a good example of how the service has started to involve young people in their care planning. However, within feedback sessions, parents/carers raised that they generally felt uninvolved in developing a care plan and often did not have a copy of it. They described how having information about self-help techniques within a copy of a care plan would have been useful, and that they would have liked to have more written information about their child's needs. This was reiterated in young people's feedback sessions, where some stated they were not sure if they were involved in care planning, or whether they had a copy of their care plan. Finally, personalised healthy lifestyle interventions and physical health assessments are offered to young people, but this is also not being documented in care plans.

  It is important that young people and their families (with consent) are actively involved in co-producing care plans. Families should be provided with a copy of the care plans, and it should be documented if they do not want this. The team should continue using their child friendly care plan templates, and audit this on a regular basis to ensure consistent involvement of young people. Additionally, the review team recommend that the care plan template includes a section for recording physical health assessments and healthy lifestyle interventions offered, ensuring this information is clearly recorded.

- The prescribing of medication for Children and Young People in CAMHS remains the responsibility of CAMHS clinicians, significantly impacting their capacity and workload. Reviewers praised the services efforts to address broader systemic issues preventing GP support for prescribing. However, this remains an ongoing challenge, requiring continued advocacy by CAMHS and the Provider, to the Government of Jersey.

  The Provider and the CAMHS service should continue working with the Government of Jersey to achieve shared prescribing of controlled medication and relieve pressures on clinicians who prescribe**,** alongside the exploration of

alternative solutions to improve capacity and workload of the clinicians responsible for prescribing and ensuring better outcomes for children who access prescriptions through CAMHS.

Development Plan

Areas of Improvement

There were two areas for improvement identified during this inspection. The table below is the Registered Provider's response to the inspection findings.

Area for Improvement 1 **Ref:** Standard 5.1.2 **To be completed by:** 3 months from the date of inspection.	Ensure young people and their families are actively involved in co-producing care plans. Copies of care plans are to be provided to young people. Regular audit should be established to maintain consistency. Physical health assessments and healthy lifestyle interventions should be recorded in the care plan.
	Response of Registered Provider: In 2024 we updated dashboards so managers have live records of care plan compliance and can ensure all are completed and updated. Inspectors acknowledged that young people and their families were involved in co-producing care plans, but CAMHS clinicians had not always overtly described this collaborative intervention planning. It was also not always evidenced or documented that co-production had occurred. We will ensure there is improved record keeping to document co-production. We have an accessible care plan. We will ensure that young people and families receive a copy of the care plan in a format that suits. CAMHS Quality and Assurance Team will audit care plan data / records during the Spring and Autumn 2025 to monitor progress. All staff have been advised to be sure to include healthy lifestyle interventions in the care plan record.

Area for Improvement 2 **Ref:** Standard 5.2.2 **To be completed by:** 12 months from the date of inspection.	The provider and CAMHS should continue collaborating with the Government of Jersey to drive change in shared prescribing of controlled medication, alongside the exploration of alternative solutions to improve capacity and workload of the clinicians responsible for prescribing and ensuring better outcomes for children who access prescriptions through CAMHS.
	Response of Registered Provider: CAMHS do not agree with the recommendation to pursue the shared prescribing of controlled medication. We believe that controlled medication for mental health should be prescribed by licenced CAMHS medical doctors. We do not agree that GP's should prescribe controlled drugs as the JCC is recommending. CAMHS agrees in principle with shared prescribing of ADHD medication with GP's, for children and young people on settled, long term doses which have been reviewed and having a positive impact. We believe this will have benefit for CAMHS clinical capacity (reduced number of prescriptions) and make accessing repeat prescriptions easier for those in receipt of ADHD medication for longer terms (from GP's and collection from local pharmacies). In 2024, CAMHS alongside Adult Mental Health submitted a proposal to the Pharmaceutical Benefits Advisor Committee (PBAC) for consideration of shared prescribing of ADHD medication. In July 2024, PBAC gave agreement in principle. They would not approve though whilst ADHD medication remained internationally in short supply. By approving at this time, local pharmacies would be in competition with the hospital pharmacy for limited ADHD medication, ensuring an uncoordinated management of limited supplies. The CLS Minister also noted this decision would have a significant financial impact. The resolution of these issues sit outside of any ability for our CAMHS Service to progress.

	In 2024, CAMHS and Adult Mental Health also supported the development of shared prescribing guidelines for GP's for ADHD Medication. Currently GP's, and some Health Advisors to the Government, are expressing reservations about this share prescribing model. Again, this issue sits outside of the ability of the CAMHS service to progress. In terms of alternatives, as explained during the inspection, CAMHS has increased the number of prescribers, employing an additional clinical fellow and three nurse prescribers in 2024. We also engaged an additional private psychiatrist to initiate and titrate ADHD medication, thus have already increased prescribing capacity for ADHD medication. The current issue is that prescriptions are currently required monthly due to ADHD Medication supply issues, resulting from an international medication shortage which CAMHS have no ability to influence. This is having the greatest impact for those in receipt of medications. In summary, we are happy for the shared prescribing of ADHD medication to be noted in the report as something CAMHS would like to see in practice, and we will continue to engage in efforts to address, but it is not within the service ability to deliver as an improvement. Further, we have made several efforts to improve prescribing capacity but are limited to impact customer experience with current international medication shortages impacting on supply and prescription length.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for development that exist in the service. The findings reported on are those which came to the attention of the Care Commission during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, Standards and best practice.

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